DOCUMENT RESUME

ED 344 486 FL 020 320

AUTHOR Eggly, Susan; Schubiner, Howard
TITLE A Course in Speaking Fluency for Foreign Medical Residents in the United States.
PUB DATE Apr 91
NOTE 11p.; Paper presented at the Annual Eastern Michigan University on Languages and Communication for World Business and the Professions (10th, Ypsilanti, MI, April 3-5, 1991).
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS College Second Language Programs; Course Descriptions; *Cultural Awareness; *English (Second Language); *English for Special Purposes; *Foreign Medical Graduates; Graduate Medical Students; Higher Education; *Language Fluency; Medical Services; Physicians; *Pronunciation; Second Language Learning; State Universities
IDENTIFIERS Wayne State University MI

ABSTRACT

A graduate level course offered to foreign medical graduates (FMGs) at Wayne State University in Michigan was developed after a needs assessment indicated the desirability of improving the speaking fluency, pronunciation, and cultural understanding of FMGs. It was found that weaknesses in those areas, which are not assessed in the Test of English as a Foreign Language (TOEFL) exam, can result in graduates gaining admittance to an American medical residency program in which they are unable to participate fully, in which they may perceive differences in treatment, and that can result in the inadequate medical treatment for patients. The course has three objectives: pronunciation, speaking in a medical context, and cultural issues related to physician-patient relationships. Methods by which each objective is taught are discussed. The following recommendations are offered: (1) departmental or self-selection may be more useful than the SPEAK test in identifying participants; (2) the course should be offered for one semester as early as possible during the first year of the training program; (3) it should be integrated into the residency program as much as possible to avoid scheduling complications; and (4) more research is needed on the relationship between FMGs and their colleagues and patients. (LB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Geoffrey Voght
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
X This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

#24

ED344486

A COURSE IN SPEAKING FLUENCY FOR FOREIGN MEDICAL RESIDENTS IN THE UNITED STATES

Susan Eggly
English Language Institute
Wayne State University

Howard Schubiner, M.D.
Departments of Internal Medicine and Pediatrics
Wayne State University

Tenth Annual EMU Conference
on Languages and Communication
for World Business and the Professions

Ypsilanti, Michigan

Thursday, April 4, 1991

FL020320

BEST COPY AVAILABLE

BIOGRAPHICAL SKETCH

Susan Eggly is a Lecturer at the Wayne State University English Language Institute. She has a bachelor's degree in anthropology, a master's degree in linguistics and over 10 years of teaching experience. Her interest in medical language stems from her participation in several research projects involving the interaction between doctors and patients and years of tutoring foreign medical residents in English as a Second Language.

Dr. Howard Schubiner is an Assistant Professor in the Wayne State School of Medicine in the Departments of Internal Medicine and Pediatrics. He is the Program Director of the Combined Internal Medicine/Pediatrics residency program. He has clinical and research interest in the areas of psychosocial and behavioral medicine.

Good medical care requires good communication between patients and their physicians and between physicians and their colleagues and support staff. A major ingredient in communication is cultural sensitivity--in order to properly diagnose and treat a patient, doctors need to be sensitive to the social and cultural background of their patients. As a way to enhance the residency training program at Wayne State University, we have created a course in speaking fluency in English and the culture of the United States for foreign medical graduates.

In order to focus on the training of foreign medical graduates, we can begin by looking at the two essential aspects of good medical care: the biomedical and the psychosocial. Traditionally, western medical schools around the world have placed most of their emphasis on the biomedical aspect, providing extensive training in the science and technology of diagnosing and treating patients. But the psychosocial and cultural aspects of medical care have been glaringly omitted.

Medical schools in the U.S. tend to be negligent in preparing students for a holistic, psychosocial approach to curing their patients. Any of us who has been a patient in a hospital, a clinic, or an emergency room is well aware that many American doctors can be rude or sensitive, lacking interest in anything other than "the presenting complaint". We often leave a doctor's office feeling slighted or hurt, in spite of the fact that we somehow believe that our medical problem has been taken care of.

However, U.S. medical schools and residency programs are beginning to take notice of research from fields such as psychology, anthropology, sociology and nursing which are pointing out the importance of understanding the social and cultural background of patients in order to provide better medical care. For example, Arthur Kleinman describes the medical system as a "clinical reality", looking at patients, practitioners and the entire health care system as socially and culturally constructed. (Kleinman, Patients and Healers in the Context of Culture, 1980) Alan Harwood talks about ethnicity and medical care, showing that people's ethnic culture forms not only their fundamental styles of interpersonal behavior and concerns about the world, but also their attitudes about health and illness. (Harwood, Ethnicity and Medical Care, 1981) Wayne State University's School of Nursing now offers a graduate program in transcultural nursing care, dedicated to teaching nurses the importance of sensitivity to their patients' ethnic and cultural needs.

Considering the great diversity of social classes and cultural and ethnic groups in the United States, differences between doctors and their patients can be extreme. Our

residency program at Wayne State's Department of Internal Medicine provides treatment for patients from the Detroit metropolitan area; by that we infer that our patients might be rich or poor, black or white, Polish-American or Arab-American, English-speaking or non-English-speaking. Patients suffer from health issues related to urban life in the United States: heart attacks, high blood pressure, diabetes, AIDS and drug-addiction. Add to this very complicated situation a physician who was raised and medically trained in a different, non-English-speaking country, facing the culture shock of a new, diverse "clinical reality".

Each year, there are more and more Foreign Medical Graduates (FMGs) trained in U.S. residency programs. In fact, 15% of all residency position in the United States are filled by FMGs, although not all of them are non-native speakers of English or non-citizens of the United States. In Wayne State's Department of Internal Medicine this year, 43 out of 63 first-year residents are FMGs and only one of those is a native speaker of English. They are generally extremely well-trained and well-qualified for the biomedical aspect of what they do, but they are, in many cases, not prepared linguistically and culturally for the psychosocial aspect of caring for patients.

A foreign medical graduate, or FMG, is a medical resident in a U.S. medical residency training program who received his/her medical degree in a country other than the United States. For the purposes of this project, however, we will exclude those FMGs who are citizens of countries whose native language is English; in other words, we are defining FMGs as medical residents who are non-native speakers of English.

Admission to U.S. medical residency programs is extremely competitive, especially in university hospitals; only the most highly-qualified FMGs are admitted. In order to enter a U.S. medical residency program, FMGs have to be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). To earn this certification, FMGs are required to pass an exam which has two components: a medical science and an English language proficiency component. The English component is equivalent to the TOEFL (Test of English as a Foreign Language). Therefore, all FMGs currently in U.S. medical residency programs have demonstrated a high level of proficiency in the areas assessed by the TOEFL exam--but the TOEFL does not assess speaking fluency or pronunciation, nor does it test cultural understanding.

It can be asserted that failure to assess overall comprehensibility in spoken English is a serious oversight which can result in situations in which physicians gain admittance to a program in which they are not fully capable of participating. In addition, FMGs may perceive differences

in treatment within the residency program, and may not be considered as equal to their American colleagues as a result of their linguistic and cultural differences. And most serious of all, failure to ensure that all physicians in a medical residency training program are fully qualified to participate can result in the administration of improper medical treatment.

NEEDS ASSESSMENT

Having established the potential for complications in the medical relationships of foreign medical graduates based on cultural difference or English language deficiency, we decided to evaluate the need for a course to deal with the problem in our department. Some members of the department felt that the FMGs would be offended by the suggestion of additional English help; we felt that they would welcome the opportunity. There were two areas to be evaluated.

1) What percentage of first-year FMGs needed improvement in their English speaking skills?

2) What percentage of first-year FMGs would be interested in a course to improve their spoken communication with their patients and colleagues?

In order to assess the level of proficiency in spoken English, we turned to an internationally recognized speaking test created by the Educational Testing Service known as the SPEAK test, or Speaking Proficiency in English Assessment Kit. Although the test was voluntary, 26 of last year's 30 first-year FMGs took it, and only thirteen of them (50%) received a passing score.

The second aspect of this needs assessment was a questionnaire which asked FMGs about language background and interest in studying more English. An overwhelming 81% indicated an interest in studying more English.

It was clear, then, that there was not only a need for a course in spoken English, but there was also a strong desire for it on the part of the FMGs. Although we had not evaluated the need for a component of the course to include cultural information, we felt strongly that current research and anecdotal evidence supported that need.

COURSE DEVELOPMENT

The next aspect of the project included the design and development of the course.

COURSE DESIGN

It was difficult to design a course to meet the need for residents in the WSU residency programs because of their rigorous work schedule, their monthly change in rotations, and the fact that their rotations take place in several locations around the Detroit metropolitan area. The eventual course design consisted of a semester-length course which met one evening a week for an hour-and-a-half. In order to compensate for the fact that first-year residents are on call every four nights, we had to offer the same class on two separate evenings each week.

SELECTION OF RESIDENTS

There were three ways through which a resident could enter the course: 1) failure to score 250 or above on the SPEAK test; 2) recommendation by the department; or 3) requesting to participate in the course. No resident was required to take the course because we believed that residents had to be highly motivated in order to benefit from this addition to their difficult daily schedule. The resulting class included nine residents. Among the nine residents, six countries and native languages were represented: Greece, Syria, Iran, Pakistan, Taiwan, and Thailand.

COURSE OBJECTIVES

The course had three objectives: pronunciation, speaking in a medical context, and cultural issues related to physician-patient relationships.

(SHOW VIDEO: the video and accompanying transcripts are taken from role-plays of medical interactions videotaped on the first night of class. Videotaped examples are provided of the type of difficulties encountered by the FMGs stemming from a need for more work on language and culture as they relate to medical interactions.)

Pronunciation

Pronunciation was taught through the use of books and tapes providing theory and practice in all aspects of pronunciation: formation of vowels and consonants and patterns of rhythm, stress and intonation. In addition, we had the use of the Visi-Pitch, a computer which visually displays sound as it is produced onto the computer screen.

It is extremely useful as visual feedback for people who cannot hear their pronunciation errors, especially the suprasegmental errors of rhythm, stress and intonation. (It also looks very high-tech, and students in scientific fields are always very impressed, which makes pronunciation work fun.) Although it is often difficult to see dramatic and rapid progress in pronunciation, through theory and practice, students can heighten their awareness of their individual problems in pronunciation and learn ways to improve in those problem areas.

Speaking in a Medical Context

This aspect of the course was intended as a transition from pronunciation theory to speaking in the medical environment; e.g., communicating with patients in the clinic or at the bedside, relating to patients' families, giving case presentations in meetings, asking questions of colleagues and faculty or requesting help from support staff. This was generally taught through role-playing and video feedback. Residents found this to be extremely valuable; they had been somewhat aware of their problems in grammar and pronunciation, but they were less aware of their overuse of technical jargon or underuse of idiomatic English. They were shocked to watch a video-tape of themselves and notice that they lacked the vocabulary or cultural understanding to be able to assess a patient's problem or explain a procedure in a non-technical, non-threatening way. Through this process, they not only got an accurate assessment of their linguistic weaknesses, but they also learned ways to compensate for those weaknesses through the use of techniques such as gestures, asking for understanding or asking for clarification. In addition, they learned ways to build rapport in order to relax and elicit confidence from patients. It also gave them the opportunity to ask questions about how people really use language, as opposed to the way they had been taught in textbooks.

U.S. Culture as Related to Medicine

Although there were some classes and discussions devoted specifically to this topic, this aspect of the course wove its way into every moment of every class. Topics that were selected for discussion included the history, culture and dialect of urban Blacks, who comprise the majority of the patients seen by these residents; relationships with American nurses; and understanding and assessing cultural differences in patients. In addition, each evening's class began with time for general questions, and this period was very productive. Residents never ceased to surprise me with their questions, which ranged from holidays to swearing to dating and sex--these are topics which they cannot safely ask their patients or colleagues. This was time for the residents to relax and chat, commiserate, complain and question--something

that is not part of their daily schedule and is sorely needed.

CONCLUSIONS AND RECOMMENDATIONS

Before offering the course, theoretical and anecdotal evidence indicated to us the need to supplement our medical residency training program with a special course for FMGs. Through the use of a speaking assessment exam and a questionnaire, we became convinced that there was not only a need, but there was a strong desire for such a course. After having offered the course to nine medical residents, we strongly urge that this type of course be offered on a regular basis to incoming foreign medical residents at residency training programs throughout the United States. We felt that the objectives and the flexible and integrated nature of the curriculum as well as the materials for the course were well-suited to the needs of the residents.

Comments from the residents were overwhelmingly approving of the course; in fact, seven of the nine residents insisted that the course continue for a second semester. Their comments indicated that the course had helped them with various aspects of their spoken English, provided them with cultural insights to which they had no access in their workplace, and, best of all, provided them with the opportunity to relax and commiserate with fellow FMGs with the support of an ESL specialist who could help them understand and work through their culture shock. According to the residents, the biggest drawback to the course was having to attend the class at night after a long day (or often two days and one night) at work, and not having time in their daily schedule to devote to practicing what they learned in class. In addition, they complained that the course was not offered to second- and third-year residents, whose language skills they believe are also somewhat lacking.

Recommendations for the future of a course such as this are the following. First, the SPEAK test as a method of selecting residents for the course was extremely time-consuming, and didn't prove to be a good predictor of which residents would eventually join the course. Instead, residents can be selected for the course through recommendation by the department or through request by the residents themselves. However, some administrators might prefer an objective exam as a method of selection in order to remove some of the social stigma involved in being asked to join the course.

Second, the course should be offered for one semester as early as possible during the first year of the training program. The second semester of the course proved to be less useful; as the residents became more comfortable in their

program, they were less motivated to attend the class. It was the first few months of the residency that were extremely difficult and that required the most support.

Third, this course should be integrated into the residency program as much as possible to avoid the class being offered at an inconvenient time and location. Although this might require the addition of an ESL specialist to the staff of a residency program, it would allow for a much more flexible and integrated program; for example, there could be informal lunches with FMGs and American medical grads to discuss and work through their differences, or intensive pronunciation work for those FMGs who require it, or occasional workshops on cultural topics of interest.

Finally, research specific to the relationship between FMGs and their colleagues and patients needs to be conducted. As more and more FMGs fill residency positions in the United States, it becomes essential that medical faculty respond to the particular needs of FMGs. Research questions might include an assessment of patient attitudes toward FMGs, compliance to treatment when the doctor is a non-native speaker of English, and specific areas of difficulty for foreign medical residents. Another important area of research, and one which we intend to pursue, is a method of quantitative and qualitative evaluation of our course in order to convince more residency training programs of its value.

REFERENCES

Bogdonoff, Morton D., and Joseph J. Fins. "University Medical Center Participation in Residency Training Programs for Graduates of Foreign Medical Schools." Annals of Internal Medicine, Volume 114, Number 5, March, 1991.

Harwood, Alan. Ethnicity in Medical Care. Boston, Harvard University Press, 1981.

Kleinman, Arthur. Patients and Healers in the Context of Culture. Berkeley and Los Angeles, University of California Press, 1980.